TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Robert P Wills, MD

Respondent Name
Phoenix Insurance Co

MFDR Tracking Number
M4-17-0492-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
October 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We do not agree with this denial as the service billed is within the DWC treatment guidelines, the appropriate allowance has not been provided, all documents to support the billing were sent twice to the carrier, the billing includes accurate coding aligned with Medicare, and the carrier's denial reasons are invalid."

Amount in Dispute: $1,311.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to separate reimbursement for the individual drug screen panels. The Carrier has reviewed the Medicare coding edits applicable to urine drug screens and disagrees. The Carrier contends reimbursement for the panels is included in the reimbursement for the urine drug screen itself as they were performed during the same patient encounter. Consequently, the Provider is not entitled to separate reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2015	Urinary Drug Screens	$1,311.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - W3 – Additional payment made on appeal/reconsideration
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
   - 6578 – Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for professional medical services provided on November 11, 2015.

   Specifically Procedure Codes;

   - G6052 - Assay of meprobamate
   - G6045 - Assay of dihydrocodeinone
   - G6046 - Assay of dihydromorphinone
   - G6056 x 4 units - Opiate(s), drug and metabolites, each procedure
   - G6041 - Alkaloids, urine, quantitative
   - 82542 x 2 units - Column chromatography, includes mass spectrometry, if performed (eg, HPLC, LC, LC/MS, LC/MS-MS, GC, GC/MS-MS, GC/MS, HPLC/MS), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen
   - G6042 - Assay of amphetamine or methamphetamine

   The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 243 – "The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed."

   28 Texas Administrative Code §134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers'
   >
   > > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the 2015, Chapter 10 of the Pathology / Laboratory Services CPT codes 80000 – 89999 for National Correct Coding Initiative Policy Manual found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, Page X-8 states,

HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened.

Also found was found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1105.pdfMLN Matters® Number: SE1105, Effective January 1, 2011, CMS will utilize two test codes to report drug screen testing:

*CMS also revised the descriptor for code G0431 to emphasize that the code describes **all screening for multiple drug classes per patient encounter.***

*G0431 (Drug screen, qualitative; **multiple drug classes** by high complexity test method (for example, immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. Note that the descriptor has been revised for CY 2011. This code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:*

- *G0431 may only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).*
- *CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.*
- *CLIA moderate complexity tests should be reported under test code G0434 with one (1) Unit of Service (UOS).*
- *G0431 may only be reported once per patient encounter.*
- *Laboratories billing G0431 must not append the QW modifier to claim lines.*

As the description of Procedure Code G0431 indicates "multiple drug classes" and "per patient encounter" the carrier's denial is supported.

2. Based on the above, the Division cannot recommend additional payment. Although the requestor has included other information with the request for MFDR only the information specific to the claim for the injured worker and relative to the denial found on the explanation of benefits for the date of service November 11, 2015 was considered in this review.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 12, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.